SELF-ADMINISTRATION/SELF-CARRY SCHOOL MEDICATION AUTHORIZATION FORM

Lemont High School • 800 Porter Street • Lemont, IL 60439 • Phone: (630) 243-2321 • Fax: (630) 243-7904 • www.lhs210.net

This form must be completed annually for each self-administer/self-carry medication and will be maintained in the Nurse's Office.

Student's Name: _____ **Birth Date:**____ / ____/ _____ **Grade: 8 9 10 11 12**
(please circle)

Address:_____
(Street) **(City)** **(State)** **(Zip)**

Phone: ( ) _____ **Parent/Guardian E-Mail Address:**_____

Students are prohibited from self-carrying and/or self-administering medications (both prescription medications and over-the-counter medications), with the exception of: (i) asthma medication and/or epinephrine auto-injectors (if authorized herein); and (ii) diabetes monitoring supplies and insulin (per applicable Student Handbook provisions).

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN, A PHYSICIAN'S ASSISTANT, OR AN ADVANCED PRACTICE REGISTERED NURSE *(***Note:** *For asthma inhalers only, please also attach the prescription label to this form)*

Physician's Name: _____ **Phone:** ( ) _____

Address:_____
(Street) **(City)** **(State)** **(Zip)**

MEDICATION	PURPOSE	DOSAGE	ROUTE	FREQUENCY/CIRCUMSTANCES/ TIME OF ADMINISTRATION

Prescription Date: ____/____/____ **Order Date:** ____/____/____ **Discontinuation Date:** ____/____ / ____

Diagnosis Requiring Medication:_____ **Time Interval for Reevaluation:** _____

Expected Side Effects/Special Instructions (if any): _____

Is it necessary for this medication to be administered during the school day? *(please circle)* **YES NO**

The student may: *(please circle one)* **SELF-CARRY ONLY SELF-ADMINISTER ONLY SELF-CARRY & ADMINISTER**

Equipment Prescribed by Physician: _____

Student's Other Medications: _____

Physician's Signature:_____ **Date:** _____/_____ / _____

For parents/guardians of students who are authorized to self-carry and/or self-administer asthma medication and/or an epinephrine auto-injector

I authorize Lemont High School District 210 and its employees and agents to allow my child or ward to self-carry or self-carry and self-administer (as specified above) his/her asthma medication and/or epinephrine auto-injector (as specified above) while (1) in school, (2) at a school-sponsored activity, (3) under the supervision of school personnel, or (4) before or after normal school activities on school-operated property. **The only medications (both prescription and over-the-counter) that students are permitted to self-carry and/or self-administer are: (i) asthma medication and/or epinephrine auto-injectors (if authorized above and as authorized above); and (ii) diabetes monitoring supplies and insulin (per applicable Student Handbook provisions).** Back-up medication may be stored in the Nurse's Office. I acknowledge that District 210 and its employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of asthma medication and/or epinephrine auto-injector and agree to indemnify and hold harmless District 210 and its employees and agents regardless of whether authorization was given by the student's parent/guardian or the medical professional specified above. I indicate receipt of this information and authorize my child or ward to carry and use his/her asthma medication and/or epinephrine auto-injector. **PARENT/GUARDIAN INITIALS** _____

For all parents/guardians

I acknowledge that I am primarily responsible for administering medication to my child or ward. However, in the event that I am unable to do so, or in the event of an emergency, I authorize Lemont High School District 210 and its employees and agents, on my behalf, to administer or to attempt to administer to my child or ward the lawfully prescribed medication described above in the manner described above. **I acknowledge that it may be necessary for the administration of medication to my child or ward to be performed by an individual other than a school nurse and specifically consent to such practices**. I agree to indemnify and hold harmless District 210 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or self-administration of medication. **I acknowledge that the only medications (both prescription and over-the-counter) that students are permitted to self-carry and/or self-administer are: (i) asthma medication and/or epinephrine auto-injectors (if authorized above and as authorized above); and (ii) diabetes monitoring supplies and insulin (per applicable Student Handbook provisions).** It is my responsibility to notify the School Nurse of any change in my child's health status or medication/health procedure. **This authorization is effective for the duration of the school year during which the form is signed by the parent/guardian. This form must be renewed for each subsequent school year. I understand that I may revoke the authorizations contained herein at any time in writing.**

Parent/Guardian's Name (printed): _____ **Emergency Phone:** ( )_____

Parent/Guardian Signature: _____ **Date:** _____/_____ / _____ **rev. 1/23**